STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COME	PLETED
		155671	B. WING		- 08/31/	2011
			_	ET ADDRESS, CITY, STATE, ZIP CO	DF	
NAME OF F	PROVIDER OR SUPPLIER			3 23RD ST	J.E	
OAKWO	OD HEALTH CAMP	US	I .	L CITY, IN47586		
			ID			(V5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO		(X5) COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AP DEFICIENCY)		DATE
F0000						
10000						
	This visit was for	r Investigation of	F0000	The submission of this	plan of	
	Complaints IN00	_		correction does not in	dicate an	
	IN00094420.			admission by Oakwoo		
	11100094420.			Campus that the findir		
	G 1: ( D100)	204410 G 1 + + + 1		allegations contained		
	•	094418 - Substantiated.		an accuratwe true rep of the quality of care a		
		iciency related to the		provided to the resider		
	allegations is cite	ed at F203.		Oawood Health Camp		
				facility recognized its	•	
	Complaint IN000	094420 - Substantiated.		provide legally and me		
	Federal/state defi	iciency related to the		necessary care and se		
	allegations is cite	ed at F329.		residents in a econom efficient manner.The of		
				hereby maitains it is in		
	Survey dates: Au	igust 30 and 31, 2011			compliance wth the requirements	
	Burvey dutes. Hu	igust 50 und 51, 2011		of participation for con	•	
	Facility number:	002512		health care facilities(fo		
	Provider number			programs.To this end,	•	
				correction shall serve		
	AIM number: 20	00278690		allegation of complian state and federal requ		
				governing the manage		
	Survey team: Jei	nnie Bartelt, RN		this facility. It is thus s		
				as a matter of statute		
	Census bed type:					
	SNF: 16					
	SNF/NF: 67					
	Residential: 21					
	Total: 104					
	10ta1. 104					
	Census payor typ	na:				
	Medicare: 24					
	Medicaid: 36					
	Other: 44					
	Total: 104					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

H1AB11

Facility ID:

002512

TITLE

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155671			(X2) MULTIPLE CC A. BUILDING B. WING	00		E SURVEY PLETED /2011
	PROVIDER OR SUPPLIER		1143 23	ADDRESS, CITY, STATE, ZIP BRD ST HTY, IN47586	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Sample: 5 These deficienci	es also reflect state				
		accordance with 410 IAC				
	Quality review of 1, 2011 by Bev I	completed on September Faulkner, RN				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DING	00	COMPL	ETED
		155671	A. BUILDING B. WING  00  08/31/2011			011	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	L		1143 23			
OVKWO	IVANCOD LIE ALTIL CAMPUIO				ITY, IN47586		
UAKWU	OAKWOOD HEALTH CAMPUS			I TELL C	11 1, 11147 300		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0203 SS=D	resident, the facilit and, if known, a fa representative of t or discharge and t writing and in a lar	ansfers or discharges a by must notify the resident amily member or legal the resident of the transfer the reasons for the move in anguage and manner they d the reasons in the					
	1	record; and include in the escribed in paragraph (a)(6)					
	of this section, the discharge required						
	before transfer or of individuals in the endangered under the resident's heal allow a more immedunder paragraph ( immediate transfe the resident's urge paragraph (a)(2)(iii	de as soon as practicable discharge when the health e facility would be r (a)(2)(iv) of this section; lith improves sufficiently to ediate transfer or discharge, a)(2)(i) of this section; an r or discharge is required by ent medical needs, under it) of this section; or a esided in the facility for 30					
	(4) of this section transfer or dischar transfer or dischar resident is transfer statement that the appeal the action address and telep long term care om facility residents w	specified in paragraph (a) must include the reason for rge; the effective date of rge; the location to which the rred or discharged; a resident has the right to to the State; the name, hone number of the State abudsman; for nursing rith developmental mailing address and telephone					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

H1AB11

Facility ID:

002512

If continuation sheet

Page 3 of 17

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155671	B. WIN			08/31/2	:011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	-	
OAKWO		110		1	BRD ST		
	OD HEALTH CAMP			TELL	CITY, IN47586		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG		ency responsible for the	+	IAU	)		DATE
ı		ocacy of developmentally					
		ls established under Part C					
	•	ntal Disabilities Assistance					
	_	Act; and for nursing facility mentally ill, the mailing					
		hone number of the agency					
		e protection and advocacy of					
		uals established under the					
	Protection and Adv Individuals Act.	vocacy for Mentally III					
		review and interview, the	FO	203	Resients B, C and F suffered	l no	09/30/2011
		ensure residents were		203	ill effects from the alleged		09/30/2011
	1	of Transfer or Discharge			deficiency as stated in the		
	which included a	•			2567.All residents have the		
		3 of 3 residents reviewed			potential to be affected and through in-service and altera	tion	
		rge to an inpatient			in procedures will ensure that		
		r unit in a sample of 5			notice of transfer/discharge i		
	•	lents B, C, and F)			issued at time of transfer and	d	
	residents. (Resid	ichts B, C, and F)			contains all required information.Completion date		
	Findings include:				9/30/2011Systemic change v	vill be	
	Tilldings illetude.	•			the use of a notice of transfe		
	1 The clinical re	ecord for Resident B was			discharge form that contains	the	
	reviewed on 8/30				local ombudsman contact information and a		
	Teviewed on 8/30	7/11 at 2.30 p.m.			Discharge/Bedhold policy sig	ned	
	Nurse's Notes for	r 6/23/11 at 12:30 p.m.,			on admission.Completion da	te	
		lent noted to have			9/30/2011Staff in-serviced or		
	· ·	ion [symbol for with]			transfer/discharge notice and requirement to notify legal	ı	
		resident hitting, kicking			representative at time of		
		ng CNAs attempting to do			transfer.Completion date		
		of daily living]; resident			9/30/2011 Director of Social		
	=	eted at this time; MD			Services/Designee will monit transfer forms daily and conf		
		ng physician] notified of			the notifiction occurs at time		
	_	for with] N.O. [new			transfer.Results of monitoring	g will	
		behavior unit for eval			be forwarded to QA committee		
	-	tx [treatment], resident			montly x6 months and quarte thereafter.	erly	
	[evaluation] and	ıx [ueaunent], resident			ulerealter.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

H1AB11 Facility ID:

002512

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155671	B. WIN			08/31/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R		1143 23			
OVKINO	OD HEALTH CAMP	III.C			ITY, IN47586		
OARWO	OD HEALTH CAIVIE	03		TELLO	111, 11147 380		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	refuses staff to o	btain vital signs, resident					
	presently laying	[sic] in bed [symbol for					
		d. Family here at					
	1	e of orders from MD,					
	· ·	C/O [complaints of]					
	•	rvices notified as well,					
	will monitor resi	dent."					
	There	C/22/11 - 4.7-00					
		1 6/23/11 at 7:00 p.m.,					
		ident left the facility by					
	ambulance.						
	Documentation t	throughout the record					
	failed to indicate	the resident or resident's					
	family was issue	ed a Notice of Transfer or					
	Discharge at the						
		viiii or viwiibrori					
	Nurse's Notes or	n 6/26/11 at 12:30 p.m.,					
		ident returned to the					
		ate. The note indicated					
	1 -						
		treated for medical					
	1 ~	ary tract infection and					
	dehydration, and	the family had declined					
	for the resident t	o be treated for behaviors					
	at the hospital be	ehavior unit.					
	Nurse's Notes on	n 6/28/11 at 1:50 p.m.,					
	indicated the resident was transferred to a						
	behavior unit at a different hospital.						
	ochavior unit at a unicient nospitar.						
	A copy of a Notice of Transfer and						
	A copy of a Notice of Transfer and						
	Discharge, dated 6/28/11, was in the						
		nd failed to include					
	information on t	he name and address of					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI A. BUII		NSTRUCTION 00	(X3) DATE S COMPL		
		155671	B. WIN			08/31/2	011
NAME OF 1	PROVIDER OR SUPPLIEI	<b>"</b> ?		1	ADDRESS, CITY, STATE, ZIP CODE		
OAKWO	OD HEALTH CAMF	PIIC		1143 23	RD ST ITY, IN47586		
		STATEMENT OF DEFICIENCIES		ID	111, 11147 300		(V5)
(X4) ID PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	E	DATE
		rm care ombudsman. The					
	area of the Notic						
	1	related to the information					
	about the local le	_					
	ombudsman was	s left blank.					
	During interview	v on 8/31/11 at 4:25 p.m.,					
		ords Director indicated a					
		er or Discharge for					
		ot be located for Resident					
	В.						
		ecord for Resident F was					
	reviewed on 8/3	0/11 at 4:25 p.m.					
	Nurse's Notes fo	or 6/29/11 at 10:45 a.m.,					
		resident] ambulating					
		th Care] 100 Hall hallway					
	_	ng to kill someone' - CNA					
	1	wn hall. CNA reports					
	that when this re	es entered his room he					
	charged @ room	mate stating he was going					
		A reports she stood					
		ts. This resident left room					
		staff. States 'he has					
	1	oot too many times.'					
		notified immediately. 1:1					
		nitoring] initiated [symbol s. Res roommate					
	reassured of safe						
	i cassured or sale	Ay.					
	Nurse's Notes or	n 6/29/11 at 12:45 p.m.,					
		ician's order was received					
		e resident to a hospital					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DING	00	COMPL	ETED
		155671	A. BUII B. WIN			08/31/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	E OF PROVIDER OR SUPPLIER			1143 23			
OVRIVIO	OD HEALTH CAMP	IIIC			ITY, IN47586		
OAKWO	OD HEALTH CAIVIE	03		I IELL C	11 1, 11147 380		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	behavior unit.						
	A Resident Trans	sfer Form indicated the					
		ensferred on 6/29/11.					
	lesident was tran	131CITCG OII 0/29/11.					
		n the record failed to					
		e of Transfer or Discharge					
	was issued to the	e resident or family.					
	On 8/30/11 at 6:0	00 p.m., the Medical					
		or indicated she was					
	•	documentation of a					
		er or Discharge issued for					
	Resident F.						
	3. The clinical re	ecord for Resident C was					
	reviewed on 8/30	0/11 at 6:15 p.m.					
		•					
	Nurse's Notes on	n 7/29/11 at 9:50 a.m.,					
		received from son [name]					
	· ·						
		him et said 'I want you to					
		ver and drown me.' Son					
	said he ended the	e phone call. Son					
	requested this wi	riter check on res. This					
	writer went to ch	neck on res asked res if he					
		snack, toileting, or if he					
	•	in his recliner, res state					
		to go home.' This writer					
	-	_					
	_	gement, res sitting in w/c					
	_	K [time]. SRB [self					
	release belt] on e	_					
	appropriately. C	Call light within reach."					
	·	-					
	Nurse's Notes on	n 7/29/11 at 10:40 a.m.,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL	
AND PLAN	OF CORRECTION	155671		LDING	00	08/31/2	
		133071	B. WIN		PPPPGG GYMY GWAD GYP GODD	00/31/2	011
NAME OF	PROVIDER OR SUPPLIE	₹		1143 23	ADDRESS, CITY, STATE, ZIP CODE		
OAKWO	OD HEALTH CAMP	PUS		1	ITY, IN47586		
		STATEMENT OF DEFICIENCIES		ID	,		(V.5)
(X4) ID PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	indicated "This	writer & 2 CNAs were					
	1	n room [number of					
	1 ^	s room] when van driver					
		r et stated res was lying on					
		oom. When this nurse					
		s entered room res was					
		nach on the floor in front					
	1 ' "	el chair], SRB alarm was					
	1	as assessed et found to					
	1	ible injuries, old S/T [skin					
	1	elbow noted to be					
	1	eding, first aid provided.					
	1 *	ark]s WNL [within					
		.When asked how he fell,					
	1	wanted out of this' and					
	1	RB. [Name of attending					
	~	called et notified per					
	1 * * *	S [Director of Health					
	1	rc'd [received] may					
	I -	e of hospital] for psych					
	1	al et tx. [Name of					
		ian] called son [name] to					
	notify of fall et of						
	placement"	F2, 311					
	1						
	The record indic	ated a Notice of Transfer					
	or Discharge, da	ted 7/29/11, with the					
		nation blank: Resident is					
	1	d to: Another Health					
	1 -	Specify Facility Name);					
	1 ,	harge to Address (number					
	1	sfer/Discharge to City,					
	State, ZIP Code;	<b>U</b> ,					
	1	ame, Telephone Number,					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155671		(X2) MULTIPLE CO A. BUILDING B. WING	00	l` ´	E SURVEY PLETED (2011	
	PROVIDER OR SUPPLIER		1143 23	ADDRESS, CITY, STATE, ZIP C BRD ST ITY, IN47586	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	and Address (nu and ZIP code).	mber and street, city, state				
	with the DHS an indicated complete Transfer and Disresponsibility.	on 8/31/11 at 3:00 p.m., ad Social Worker, they eting the Notice of echarge was a nursing  is related to Complaint				

AND PLAN OF CORRECTION  IDENTIFICATION NUMBER: 156671  NAME OF PROVIDER OR SUPPLIER  OAKWOOD HEALTH CAMPUS  SUMMARY STATEMENT OF DEPICIENCIES  (XA) ID SUMMARY STATEMENT OF DEPICIENCIES  REPETX  (RACH DEPICIALY MIST BE PERCEIDED BY TRILL  TAG  REGULATIONY OR, SEE DENTIFYING INFORMATION)  TAG  REGULATIONY OR, SEE DENTIFYING INFORMATION  TAG  SECULATIONY OR, SEE DENTIFYING INFORMATION  TAG  SECULATION OR, SEE DESCRIPTION  TO COMPRETED  TELL CITY, INATES  TELL	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
NAMI-OF PROVIDER OR SUPPLIER  OAKWOOD HEALTH CAMPUS  (EACH DEFICIENCY MIST BE PERCEDED BY PULL REGULATORY OR IS.C IDENTIFYING INFORMATION)  TAG  REGULATORY OR IS.C IDENTIFYING INFORMATION)  FOR 29  Each residents for up regimen must be free from unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate monitoring; or without adequate monitoring; or without adequate should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug are not given these drugs unless antipsychotic drug are not given these drugs unless antipsychotic drugs are not given these drugs unless antipsychotic drug are not given these drugs.  Based on record review and interview, the facility failed to ensure an attempt at gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  Based on record review and interview, the facility failed to ensure an attempt at gradual dose reduction of an antipsychotic medication and interviewed their medications and evaluation of encessity with physician for continued use. Completion date 92/20/2011/Lillicensed nursing personnel and Social Service Director in serviced on indications for use of antipsychotic medication and lowest therapychotropic	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIJII.	DING	00	COMPL	ETED
NAME OF PROVIDER OR SUPPLIER OAKWOOD HEALTH CAMPUS  THELE CITY, IN47566  IN43 23RD THELE CITY, STATE, ZIPCODE THAG 23RD THE COMPLIENCES  THE COMPLITION THE COMPLITION OF THE COMPLIENCES THE COMPLITION OF THE COMPLITION THE COMPLITION OF THE COMPLITION OF THE COMPLITION THE COMPLETION THE COMPLITION THE CO			155671	l			08/31/2	011
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFY TAG REGULATORY OR LSC IDENTIFY	OAKWO	OD HEALTH CAMP	us	STREET ADDRESS, CITY, STATE, ZIP CODE 1143 23RD ST TELL CITY, IN47586				
Fig. 29 SS=D  Regulatory or Isc identify No Involvation)  Each resident's drug regimen must be free from unnecessary drug. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy), or for excessive duration; or without adequate monitoring; or without appears of the research of the research of the research of the res				,				
Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  Based on record review and interview, the facility failed to ensure an attempt at gradual dose reduction of an antipsychotic medication and evaluation of necessity with physician for continued use. Completion date 9/30/2011/listing personnel and Social Service Director in-serviced on indications for use of antipsychotic medication and lowest treviewed related to psychotropic		`		·		CROSS-REFERENCED TO THE APPROPRIAT	E	
reductions per OBRA		Each resident's draftom unnecessary drug is any drug we (including duplicate duration; or without adequate in the presence of accordinate the doses discontinued; or an reasons above.  Based on a compart resident, the facilitative residents who have drugs are not give antipsychotic drugs treat a specific coordocumented in the residents who use gradual dose reduction in an effort to discontinued; or an and interventions, unless in an effort to discontinued; or an attemption of the residents who use gradual dose reduction in an effort to discontinued; or an attemption of the residents who use gradual dose reduction and interventions of the residents who are gradual dose reduction and interventions of the residents who are gradual dose reduction and interventions of the residents who are gradual dose reductions of the residents who have gradual dose reductions of the residents who are gradual dose reductions o	ug regimen must be free drugs. An unnecessary when used in excessive dose the therapy); or for excessive ut adequate monitoring; or indications for its use; or in diverse consequences which should be reduced or my combinations of the rehensive assessment of a try must ensure that the not used antipsychotic in these drugs unless therapy is necessary to indition as diagnosed and eclinical record; and entipsychotic drugs receive indications, and behavioral its clinically contraindicated, continue these drugs.  The record review it at gradual ction of an otic medication residents related to	F0.	329	reduction plan to d/c antipsyche medication per family request Completion date 9/27/2011Al residents receiving antipsyche medications have the potential be affected by the alleged deficient practice therefore DHS/designee have reviewed their medications and evaluation of necessity with physician for continued use. Completion date 9/30/2011Licensed nursing personnel and Social Services Director in-serviced on indication use of antipsychotic medication and lowest therapeutic dose as well as requirement for dosage	chotic t. II ootic al to d tion or ate	09/30/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	155671	- 1	LDING	00	COMPL 08/31/2	
		100071	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/01/2	
NAME OF F	PROVIDER OR SUPPLIER			1143 23			
OAKWO	OD HEALTH CAMP	US		1	ITY, IN47586		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	medications in a sample				guidelines.Completion date 9/30/2011SSD/designee will		
	of 5 reside	ents. (Resident			monitor Diagnoses that suppuse of antipsychotic medicat		
	D)	( 12 11 1			as well as active behaviors of	laily	
	(D)				and when reduction of medic is reasonable based on thos		
					behaviors to request from		
	Findings i	nclude:			physician.Completion date 9/30/2011Results of audits a	ınd	
					complete list of those resider receiving antipsychotic	nts	
	The elimin	al managed for			medications will be forwarde	d to	
	I ne ciinic	al record for			QA committee monthly x12 months for review and		
	Resident I	O was			suggestion.		
	reviewed	on 8/30/11 at					
	5:10 p.m.	The record					
	indicated	the resident					
	was origin	nally admitted					
	on 4/11/10	and and					
	readmitted	d on 4/26/10					
	and most	recently					
		d on 7/29/11,					
		,					
		a fall with hip					
	fracture.						
	A physicia	an's History					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL		
		155671	A. BUII B. WIN			08/31/2	011
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
OAKWO	OD HEALTH CAMP	US		1	ITY, IN47586		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
	and Physic	cal Exam,					
	dated 4/8/10, indicated						
	the resider	nt was seen by					
	the attend	ing physician					
	at a clinic	visit. The					
	History of	Present Illness					
	indicated	the family was					
	concerned	about the					
	resident li	ving alone at					
	home. Th	e Current					
	Medicatio	ns did not					
	indicate th	ne resident was					
	on Seroqu	el					
	[antipsych	notic] at home.					
	The attend	ling physician's					
	Admission	n Examination,					
	dated 4/28	8/10, indicated,					
	"Behavior	Problems:					
	Paranoid (	a times,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLI AND PLAN OF CORRECTION IDENTIFICATION NUM  155671		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING  B. WING			- 08/31/2011		
NAME OF PROMINER OR GUIDNIER					ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER			1143 23RD ST					
	OD HEALTH CAMP			ļ	ITY, IN47586		(15)	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	appears ar	nxious &						
	depressed."							
	1							
	Physician'	s orders for						
	•	11 included,						
	but were not limited to,							
	an order originally							
	received 4/26/10 for							
	"Seroquel 300 mg tablet,							
	give 1 tab orally every 1700 [5:00 p.m.]"  A Note to Attending Physician/Prescriber,							
	dated 4/21	/11, and						
	signed by	the Registered						
	Pharmacis	st, indicated,						
	"This re	sident is						
	currently	receiving the						
	following	antipsychotic:						
	_							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155671		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		Со	(X3) DATE SURVEY COMPLETED 08/31/2011			
NAME OF PROVIDER OR SUPPLIER  OAKWOOD HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE  1143 23RD ST  TELL CITY, IN47586					
SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
Seroquel 3	300 mg at 1800							
[6:00 p.m.] since April								
2010. Ple	ase evaluate							
therapy at	this time." A							
check mai	k was placed							
next to, "GDR [gradual								
dose reduction]								
contraindicated; patient								
likely to experience								
exacerbation of								
symptoms." The								
documentation was								
signed by the physician								
on 4/22/11	1.							
The Resid	lent Care Plan							
with the d	ate of 7/29/11							
indicated	a problem for							
"Psychotr	opic Drug Use.							
_	1							
	PROVIDER OR SUPPLIER OD HEALTH CAMP  SUMMARY'S (EACH DEFICIEN REGULATORY OR Seroquel 2 [6:00 p.m. 2010. Ple therapy at check mannext to, "O dose reduction to the exacerbation symptoms document signed by on 4/22/12. The Residucit with the dindicated "Psychotre"	DROVIDER OR SUPPLIER  OD HEALTH CAMPUS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Seroquel 300 mg at 1800  [6:00 p.m.] since April 2010. Please evaluate therapy at this time." A check mark was placed next to, "GDR [gradual dose reduction] contraindicated; patient likely to experience exacerbation of symptoms." The documentation was	IDENTIFICATION NUMBER: 155671  A. BUILD ROY IDENTIFICATION NUMBER: 155671  B. WIN  PROVIDER OR SUPPLIER  OD HEALTH CAMPUS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Seroquel 300 mg at 1800  [6:00 p.m.] since April 2010. Please evaluate therapy at this time." A check mark was placed next to, "GDR [gradual dose reduction] contraindicated; patient likely to experience exacerbation of symptoms." The documentation was signed by the physician on 4/22/11.  The Resident Care Plan with the date of 7/29/11 indicated a problem for "Psychotropic Drug Use.	DENTIFICATION NUMBER: 155671  STREET A 1143 23 TELL C  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Seroquel 300 mg at 1800  [6:00 p.m.] since April 2010. Please evaluate therapy at this time." A check mark was placed next to, "GDR [gradual dose reduction] contraindicated; patient likely to experience exacerbation of symptoms." The documentation was signed by the physician on 4/22/11.  The Resident Care Plan with the date of 7/29/11 indicated a problem for "Psychotropic Drug Use.	OF CORRECTION 155671  DENTIFICATION NUMBER: 155671  A BUILDING R. WING  PROVIDER OR SUPPLIER  OD HEALTH CAMPUS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Seroquel 300 mg at 1800  [6:00 p.m.] since April 2010. Please evaluate therapy at this time." A check mark was placed next to, "GDR [gradual dose reduction] contraindicated; patient likely to experience exacerbation of symptoms." The documentation was signed by the physician on 4/22/11.  The Resident Care Plan with the date of 7/29/11 indicated a problem for "Psychotropic Drug Use.	OF CORRECTION    155671     A BUILDING   B WING     CO 08/3		

AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  00			(X3) DATE SURVEY COMPLETED	
		155671	A. BUILDING  B. WING			08/31/2011		
NAME OF PROVIDER OR SUPPLIER			•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•		
OAKWOOD HEALTH CAMPUS					ITY, IN47586			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
	places resident at risk for							
	drug-related: [check							
	mark next to] gait							
	disturbanc	ee."						
	Interventi	ons included,						
	but were not limited to,							
	"Work with							
	physician/pharmacy to							
	provide lowest							
	therapeutic dose."							
	During interview on							
	8/31/11 at 3:30 p.m., the							
	Social Wo	orker indicated						
	she was u	nsure why the						
	physician	did not agree						
	to an atter	npt at gradual						
	dose redu	ction of						
	Seroquel 1	for Resident D.						
	The Socia	l Worker						

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFE		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155671	A. BUI	LDING	NSTRUCTION 00	CON	TE SURVEY MPLETED 1/2011	
NAME OF PROVIDER OR SUPPLIER  OAKWOOD HEALTH CAMPUS			B. WING STREET ADDRESS, CITY, STATE, ZIP CODE  1143 23RD ST  TELL CITY, IN47586					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	indicated the resident's							
	only beha	vior was						
	resistance	to care, and						
	she indica	ted she had no						
	record of	that behavior						
	when she	checked the						
	computerized records of							
	behaviors for Resident D							
	for recent months. The							
	Social Worker indicated							
	maybe the	e physician						
	talked to the family or							
	had other	knowledge						
	from the r	resident's						
	history rel	lated to the use						
	of the anti	psychotic.						
	This feder	ral tag is related						
	to Compla	aint						
	IN000944	-20.						

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155671		(X2) MULTIPLE CC  A. BUILDING  B. WING	00	li i	E SURVEY PLETED /2011			
NAME OF PROVIDER OR SUPPLIER  OAKWOOD HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE  1143 23RD ST  TELL CITY, IN47586					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
	3.1-48(b)(3.1-48(b))	(2) (4)						